TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

MFDR Tracking Number
M4-17-1449-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
January 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Health Resources is disputing Travelers Insurance decision to deny payment based solely on their belief that the services received . . . are not compensable and/or the medical documentation provided is insufficient to substantiate Trauma activation."

Amount in Dispute: $243,367.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: ". . . the Provider submitted billing to the Carrier, which reviewed and denied reimbursement as the documentation did not support how the admission was related to the compensable injury."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2016 to February 11, 2016	Inpatient Hospital Services	$243,367.63	$48,534.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
4. 28 Texas Administrative Code §133.250 sets out requirements for reconsideration of payment for medical bills.
5. 28 Texas Administrative Code §133.500 establishes standards and formats for electronic medical bill processing.
6. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.
7. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
8. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuance of an adverse determination.
9. 28 Texas Administrative Code §19.2011 sets out procedures for appeal of adverse determinations.

10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
    - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
    - 169 – REIMBURSEMENT BASED ON RATIO, PERCENTAGE OR FORMULA SET BY STATE GUIDELINES.
    - 4157 – OUTLIER PAYMENT APPLIED TO COVERED INPATIENT HOSPITAL SERVICE.
    - 268 – PLEASE SUBMIT SUPPORTING DOCUMENTATION IDENTIFYING MEDICAL NECESSITY FOR THE PROCEDURE BILLED.
    - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Are there unresolved issues of compensability, extent of injury or liability for the claim?
2. Are there any unresolved issues of medical necessity regarding the disputed dates of service?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended reimbursement for the services in dispute?
5. Is the requestor entitled to additional payment?

Findings

1. The respondent's position statement asserts that the insurance carrier "reviewed and denied reimbursement as the documentation did not support how the admission was related to the compensable injury."

   28 Texas Administrative Code § 133.240(a) requires that:

   > An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

   28 Texas Administrative Code §133.240 (e) requires that:

   > The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title . . . The explanation of benefits shall be sent to:
   > (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill . . .

   28 Texas Administrative Code §133.250(g) requires that:

   > The insurance carrier shall take final action on a reconsideration request of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:
   > (1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or
   > (2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

   Final action on a medical bill is defined in 28 Texas Administrative Code §133.2(6) as:

   > (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement . . .
   > (B) denying a charge on the medical bill.

   All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules.

   28 Texas Administrative Code §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

Review of the submitted materials finds no explanations of benefits with denial reasons relating to extent of injury, compensability or relatedness to the compensable claim to support that the insurance carrier, prior to the filing of the request for medical fee dispute resolution, had raised issues of extent of injury, compensability or liability with respect to the disputed dates of service.

Rule §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The insurance carrier's failure to assert on the explanations of benefits specific denial reasons or defenses relating to the services in dispute during the bill review process—before the request for MFDR—constitutes grounds for the division to find a waiver of such defenses at Medical Dispute Resolution.

As no information was presented to support that the insurance carrier had presented denial reasons relating to extent of injury, compensability or liability for the above disputed services prior to the filing of the MFDR request, the division finds the respondent has waived such defenses with respect to these services. As there are no outstanding issues of compensability, extent of injury or liability for the disputed services, these services are eligible for MFDR and will be reviewed for payment according to applicable division rules and fee guidelines.

2. The respondent issued explanations of benefits with denial reason code 268 – "PLEASE SUBMIT SUPPORTING DOCUMENTATION IDENTIFYING MEDICAL NECESSITY FOR THE PROCEDURE BILLED."

   The division notes that this is not a denial of the medical necessity of the disputed services, but rather a documentation denial.

   The submitted information supports that the health care provider submitted sufficient documentation to the insurance carrier for the carrier to perform a retrospective review had they so chosen.

   No documentation was presented by the respondent to support that retrospective review of the medical necessity of the disputed services was conducted or that an adverse determination was issued.

   28 Texas Administrative Code §133.250(k) requires that:

   > In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor. . .

   Review of the submitted documentation finds no copy of a peer review, or a utilization review report, or that an adverse determination was issued with the required notices in accordance with the procedures and requirements set forth in 28 Texas Administrative Code §19.2010 and §19.2011. Consequently, the division finds that the disputed denial reason is not supported and that the respondent has waived any defense as to the medical necessity of the disputed services.

   As there are no outstanding issues relating to the medical necessity of the disputed services, the services will be reviewed for payment according to applicable division rules and fee guidelines.

3. Reimbursement for Inpatient hospital facility medical services provided to an injured employee is subject to the provisions of 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Information regarding IPPS reimbursement formulas and factors is available from http://www.cms.gov.

   Review of the submitted information finds that separate reimbursement for implantables was not requested.

   Rule §134.404(f)(1)(A) requires that, for these disputed services, the Medicare facility specific amount, including any outlier payment, be multiplied by 143 percent.

4. Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 507. The services were provided at Texas Health, Fort Worth. Based on the submitted DRG code, the service location, and bill-specific information, the IPPS payment calculation totals $33,911.06.

   To this amount we add back the VBP claim reduction of $29.44, which is not applicable to the services in dispute per Rule §134.404, which states that specific provisions contained in the Texas Labor Code or division rules shall take precedence over any conflicting provision adopted by CMS in administering the Medicare program. As the Value-Based Purchasing program is a quality care initiative adopted by CMS applicable to participating Medicare providers, it conflicts with and is superseded by Texas Labor Code sections providing for review and monitoring of health care quality in the Texas workers' compensation system.

   The facility specific amount is $33,940.50. This amount multiplied by 143% results in a MAR of $48,534.92.

5. The total recommended payment for the services in dispute is $48,534.92. The insurance carrier has paid $0.00. The amount due to the requestor is $48,534.92.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $48,534.92.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $48,534.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	February 24, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.